Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J JOHN STASIKOWSKI MD PA
1307 8TH AVENUE SUITE 202
FORT WORTH TEXAS 76104

Respondent Name

TARGET CORP

Carrier's Austin Representative Box

Box Number 39

MFDR Tracking Number

M4-05-1127-01

MFDR Date Received

October 14, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office received a letter from Chuck Finch Dated October 28, 2003. Mr. Finch ask [sic] Dr. Stasikowski several questions, and Dr. Stasikowski answered these questions. On the second page of Mr. Finch's letter it states, 'you may direct any billing for your time to prepare the report pursuant the Commission fee guidelines to our office, then we will forward that onto target for payment.' Please review the copy enclosed highlighted. Also, when the billing was sent to the Mr. Finch's office our office received a letter back stating to resubmit on HCFA from [sic], also enclosed. I have sent to several time [sic] to Mr. Finch's office and to the insurance company. Our office then receives another letter from Mr. Chuck Finch dated December 11, 2003, asking several more questions, and states on 2nd page 'You can direct your fees for reviewing this report and providing written answers to our office. We will then forward it on the carrier for payment. [sic] Our provider has only received one payment and that is $70.00 for DOS 12/18/2003."

Amount in Dispute: $2,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider has billed an amount totaling $2,370.00. Carrier asserts that this amount exceeds the reimbursement owed on this case. If a reimbursement is not set for these services, the reimbursement should be at only a fair and reasonable amount."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2003 and December 18, 2003	Professional services	$2,300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on December 19, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 19, 2004, to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 16, 2004 for date of service October 31, 2003
   - DUPL D – These services have already been considered for reimbursement

   Explanation of benefits dated August 16, 2004 for date of service December 18, 2003
   - DUPL D – These services have already been considered for reimbursement

   Explanation of benefits dated March 9, 2004 for date of service October 31, 2003 and December 18, 2003
   - NDOC N – The documentation that was received does not provide enough detailed information to determine appropriateness of the billed services/procedure.
   - INCD G – This procedure is considered integral to the primary procedure billed
   - PAYA F – This procedure code is reimbursed based on the maximum allowable fee for the Texas Fee Guidelines. If one is not specified, The UCR allowance for this zip code area.
   - NRPT – Report was not received or documentation received did not substantiate charge for report.

   Explanation of benefits dated August 16, 2004 for date of service October 31, 2003 and December 18, 2003
   - DUPL D – These services have already been considered for reimbursement.

Issues

1. Is the requestor entitled to reimbursement according to the Medical Fee Guideline?

Findings

1. The requestor submitted documentation and copies of the CMS1500s to identify that a questionnaire was completed at the request of the insurance carrier's attorney, Flahive, Ogden & Latson. The requestor answered several questions and billed for CPT codes 99199, 99358, 99359, 99080 rendered on October 31, 2003 and December 18, 2003.
2. The disputed dates of service are not valued by Medicare and are therefore subject to fair and reasonable reimbursement. 28 Texas Administrative Code §134.202(c)(6) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications" and "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT codes 99199, 99358, 99359, 99080.
   - Documentation of the comparison of charges to other carriers was not presented for review.

- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended for CPT codes 99199, 99358, 99359, 99080.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.